MIHP – Program Assumptions
7/6/06 (revised)

Background: the former MSS/ISS Program did not successfully target high-risk clients, driving MDHC to redesign the program.

Assumption	*Comments*
1. The Maternal Infant Health Program will be co-managed by Medicaid and the Division of Family and Community Health in participatory planning with key stakeholders including the women who participate.	MIHP will have staff from both Medicaid and DFCH staff dedicated to the program. IHCS/MSU will provider consultative/technical assistance, as needed.
2. Resources are limited, and MIHP cannot address all issues for all clients.	Community, health plan, and other resources must be leveraged and coordinated.
3. Systems of care vary among communities.	MIHP providers must be familiar with and utilize community resources.
4. The Maternal Infant Health Program focuses on motivating clients and coordinating services.	MIHP providers are responsible for referring clients to services, whenever possible. MIHP providers cannot deliver interventions that are outside their scope of professional practice. Team composition should be adjusted as needed for individual care planning.
5. MIHP is based on a population management model.	All pregnant beneficiaries and infants (maternal/infant dyad) are in the program and are included in program outcome measures.
6. MIHP has a registry that is used for population management, tracking, reporting, and outcomes measurement.	A functional database is essential for the redesigned program. Program data must be captured timely and accurately. Administrative data should be utilized, whenever possible.
7. Risks are determined systematically and periodically.	INTERVENTIONS ARE DESIGNED IN ACCORDANCE WITH LEVEL OF RISK
8. Interventions are prioritized to address (1) risks and (2) amenable domains/areas.	
9. There will be a core set of required interventions that are evidence-based; the program will allow flexibility to meet the needs of individual clients with their participation and choice.	Interventions must be defined by MIHP program staff, using information obtained from available literature. However, literature/evidence will not prescribe intervention at the "desk level" (e.g., precise numbers of contacts, etc.). Care plans must reflect desired interventions.
10. Interventions are delivered by professional providers operating within the program policy and scope.	Providers must understand their scope of practice within program design and processes; emphasis should be placed on coordination and referrals. Interventions should be relatively standard but should also accommodate professional judgment.
11. Payment is FFS by "visit" at this time.	Visit-based payment must evolve to allow for creative complements of intervention delivery; in the meantime, MIHP should explore ways to programmatically define "visits" to include: – Face-to-face encounters (home and elsewhere) – Group visits – Phone encounters – Email
12. Providers must meet program expectations, including implementation of outreach strategies.	Providers must be willing and able to participate in the redesigned program and must have the capacity to record and report data and to adhere to program policies. Expectations must be communicated to providers on a timely basis. Initially, MIHP quality oversight will include provider performance, with a goal of moving toward an increasingly performance-based program/provider relationship.
13. Providers require ongoing training and oversight.	Significant provider training will be required, including orientation to the model, risk, interventions, desired outcomes, emphasis on coordination, data reporting, etc. Initial training should focus on the program (matrix), care coordination, and motivational techniques.
14. The program is evaluated annually and is outcome based.	The evaluation process will drive future program modifications (quality improvement process).